

PSYCHOLOGY TEACHERS UPDATE

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CHILD PHYSICAL ABUSE,
NEGLECT, AND DISADVANTAGE

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PSYCHOLOGY TEACHERS UPDATE

Psychology Teachers Update is designed to give a brief overview of the main developments in the different areas of psychology. There is a proliferation of journals and research, and it is very difficult to keep abreast of the latest trends, particularly in the many and varied areas of psychology.

Each issue of Psychology Teachers Update will cover a particular topic, and summarise the main research directions and findings in the last ten to fifteen years approximately. The aim is to give teachers the feel of what is happening in that area of psychology.

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Definitions

In 1962, Kempe et al coined the term "the battered child syndrome", and this is seen as the first time that child physical abuse (CPA) was taken seriously.

As with many areas in psychology, there are no agreed definitions of what is child abuse (Korbin 1997).

Taylor (1992) noted five categories of abuse: physical injury, failure to thrive (delay in physical growth) ⁽¹⁾, sexual abuse, neglect, and emotional abuse (eg: belittling the child). Hamarman and Bernet (2000) divided emotional abuse into rejecting, isolating, terrorizing, ignoring, corrupting, verbally assaulting, and overpressuring.

While Jones et al (1987) included in their definition: sexual abuse, physical injury, inadequate supervision/leaving alone, failure-to-provide, encouraging delinquency, emotional mistreatment, educational neglect, and moral danger because of parent(s)' behaviour (eg: drug abuse).

Emery and Laumann-Billings (2002) have also distinguished child violence ("abuse that causes serious harm to a child"), and child maltreatment ("abuse that causes little or no serious harm"). The key is intentional acts or omissions by the caretaker in both cases (Emery and Laumann-Billings 1998).

Of the many definitions, some focus upon the behaviour and actions of adults, while others include the threat of harm (Runyan et al 2002).

The definition used will be linked to the perceived seriousness, and thus to the amount of behaviour measured. For example, the number of deaths of children compared to regular light smacking ⁽²⁾.

Browne and Herbert (1997) have attempted to clarify the severity of child maltreatment into four levels from "less severe" to "life-threatening" (table 1).

However:

The abuse of children has been ignored historically, and instances of abuse continue to be overlooked, minimized or wrongly perceived as minor, both in individual cases and in entire countries. The minimization of child abuse can lead to tragic results for individual children and for groups of children growing up in harmful and hurtful societal circumstances (Emery and Laumann-Billings 2002 p325).

LEVEL OF MALTREATMENT	PHYSICAL MALTREATMENT	NEGLECT
Less severe - minor incidents of an occasional nature with little or no long-term damage	Injuries limited to superficial tissue damage eg: small slight bruising	Occasional withholding of love and affection; developmental delay; child unwashed
Moderately severe - more frequent and/or serious, but not life-threatening or serious long-term effects	Surface injuries eg: extensive bruising	Frequent withholding of love; failure to gain weight; parent(s) occasional mental illness
Very severe - very frequent incidents with very severe consequences	Large and deep injuries including broken bones and damage to internal organs	Frequent unavailability of caretaker; non-organic failure to thrive; parent(s) frequent mental illness; child left alone sometimes
Life-threatening - long-term consequences and severe harm	Deliberate and persistent injuries that have potential to kill	Persistent unavailability of caretaker; child left alone often; frequent illness because of poor hygiene

(After Browne 2002)

Table 1 - Levels of severity of physical maltreatment and neglect.

Measurement of Child Physical Abuse and Neglect

Accurate measurement of the amount of child abuse is difficult because of the hidden nature of much of the behaviour ⁽³⁾. Two main methods can be used - official reported cases, and self-reported or victim surveys.

1. OFFICIAL REPORTED CASES

These are the official figures of cases of abuse reported to the appropriate authorities. From these figures, calculations can be made of the overall rate of abuse (ie: including the unreported amount of child abuse).

Nationally the Department of Health collects the figures for the Child Protection Register in England. Local authorities must register all children on their protection register. For the year ending March 2000, in total 29 300 children were registered: of which 23% were registered for physical injury, 35% for neglect, and 6% for both neglect and physical injury (Browne 2002).

Locally, for example, Sidebotham et al (2000) used the Child Protection Register in Avon to study pre-school age abuse. They calculated a rate of abuse of 10.6 - 23.3 children per 10 000 per year (table 2).

TYPE OF ABUSE	% OF TOTAL ABUSE	MORE OR LESS COMMON COMPARED TO SCHOOL AGE CHILDREN
Physical injury	31.7	less
Neglect	29.0	more
Sexual abuse	10.9	less
Emotional abuse	25.1	more
Grave concern/other	3.3	more

(After Sidebotham et al 2000)

Table 2 - Types of abuse in Avon using Child Protection Register.

In the USA, the National Center for Child Abuse and Neglect (NCCAN) collects the official figures for Congress. The figures from three NIS (National Incidence Study of Child Abuse and Neglect) showed an increase in the amount of abuse between 1980 and 1993 (table 3) ⁽⁴⁾.

Table 4 gives the breakdown of the types and severity of the abuse in NIS-3 1993 (Sedlak and Broadhurst 1996).

Rate per 1000 children	NIS-1 (1980)	NIS-2 (1986)	NIS-3 (1993)
All abuse	9.8	14.8	23.1
Physical abuse	3.1	4.3	5.7
Sexual abuse	0.7	1.9	3.2

(After Haugaard 1999)

Table 3 - Rates of abuse in the USA in three NIS.

Rate per 1000 children	OVERALL ABUSE	SERIOUS ABUSE*	MODERATE ABUSE**	INFERRED ABUSE***
Educational neglect	397	397	/	/
Sexual abuse	218	74	26	115
Emotional abuse	417	417	/	/
Physical abuse	382	50	332	/
Physical neglect	339	217	51	67

* Serious abuse defined as "a life threatening condition or long-term impairment of physical, mental, or emotional capacities, or requiring professional treatment aimed at preventing such long-term impairment".

** Moderate abuse is an injury "persisted in observable form...for at least 48 hours", and not serious enough to need professional treatment.

*** Inferred abuse means "the nature of the maltreatment gave reasonable cause to assume the injury or impairment probably occurred" (Sedlak and Broadhurst 1996 pp13-14).

(After Emery and Laumann-Billings 2002)

Table 4 - Breakdown of types and severity of abuse in NIS-3 (1993).

Emery and Laumann-Billings (2002) noted two reservations about the NIS data. Firstly, concerns about classing "educational neglect" as abuse, and, secondly, severe physical abuse was only a small part of the total amount of CPA.

There are also a number of general problems with the official figures:

a) The stages to reporting or not - in other words, not every case of abuse is reported to the authorities.

Taylor (1992) described five stages to reporting:

(i) perpetrator known to victim; (ii) perpetrator known to others; (iii) reported to professionals; (iv) investigated by authorities including substantiated or not; and (v) recognised and recorded as abuse.

The National Centre on Child Abuse Prevention Research (NCCAPR) in the US in 1998 found three million cases of reported child abuse, but only one-third of them were substantiated by a case worker (Wang and Harding 1999). Of the substantiated cases, 20% were CPA.

But McCurdy and Daro (1993) estimated that 40% of substantiated cases received no social service help in the US, and less than 20% of the substantiated cases ended in formal court action (Emery and Laumann-Billings 2002).

b) Some forms of abuse more obvious (eg: physical injury) than others, and thus more likely to be noticed or reported.

c) Families in contact with welfare services more likely to be noticed than other families.

d) Figures based on official definitions only.

2. VICTIM SURVEYS

This type of research questions a sample of people about their experiences, and can include cases never officially recorded. Generalisations from this type of research depends upon the sample used, the definition of abuse, and the accuracy of recall of the respondents (Brewer 2004).

For example, in the US, surveys have used different definitions of abuse, and found very different results. If abuse was defined as:

a) Spanking, then two-thirds of US children had suffered CPA;

b) Hitting the child with an object, then 5% of children had suffered;

c) Beating up the child, the figure is 0.5% (Gallup et al 1995).

In an example of this type of research, a random sample of nearly 1500 US households in the 1980s found that approximately 1% of families "beat up" their child(ren), and 2% kicked and hit their child(ren) (quoted in Haugaard 1999).

While 31.2% of men and 21.0% of women admitted to have experienced CPA in the Mental Health Supplement of the Ontario Health Survey, in Canada. This survey questioned 10 000 residents aged 15 years and older (MacMillan et al 1997).

3. CROSS-CULTURAL SELF-REPORTED STUDIES

The World Health Organisation (Runyan et al 2002) collected together comparable data about CPA around the world. Table 5 summarises a selection of the findings from self-reported studies in four countries. The comparability of the data are always taken with care as studies use different definitions of abuse, and different sampling procedures, as well as the variations in legal requirements to report such events.

More comparable data on the amount of CPA comes from the World Studies of Abuse in the Family Environment (WorldSAFE) (reported in Runyan et al 2002) based in Chile, Egypt, India, and the Philippines. This research recorded a number of aspects of abuse, including the rates of physical punishment from interviews with mothers using the Parent-Child Conflict Tactics Scale (Straus 1995) (table 6).

COUNTRY	YEAR OF STUDY	FINDINGS
USA	1998	Based on parents' responses: estimated rate of physical abuse of 49 per 1000 children
Egypt	1998	37% children reported being beaten or tied up by parents; 26% of those had physical injuries from it
Romania	2000	4.6% of children severe and frequent physical abuse; approx half parents beat their children "regularly"
Ethiopia	1997	21% urban and 64% rural schoolchildren had bruises and swellings on body from parental punishment

Table 5 - Four cross-cultural self-reported studies of CPA.

	CHILE	EGYPT	INDIA	PHILIPPINES
Hit child with object (not on buttocks)	4	26	36	21
Kicked child	0	2	10	6
Burned child	0	2	1	0
Beat child	0	25	no data	3
Choked child	0	1	2	1

(After Runyan et al 2002)

Table 6 - Percentage incidence of severe physical punishment in four countries in previous six months of interviews.

ABUSE IN CARE

A number of studies have found that children in care were more likely to be reported as physically or sexually abused than the general population. For example, in a British study, 7-8 times more likely for children in foster care, and six times more in residential care (Hobbs et al 1999).

Benedict et al (1994) looked at the situation in Baltimore where maltreatment reported was three times greater for foster families than non-foster families. There are possible explanations for these findings (Rushton and Minnis 2002):

a) The figures are accurate because (i) children in foster care have more risk factors for abuse, like learning disabilities or behaviour problems, or (ii) adults who want to abuse children may seek out situations to meet vulnerable children;

b) The figures are over-reported because (i) there is increased vigilance of children in foster care and any sign is perceived as abuse, or (ii) the biological parent(s) may report abuse that does not exist in the foster family or exaggerate claims in the hope of the child being returned to them.

Causes of Child Physical Abuse and Neglect

The causes of the physical abuse and neglect of children can be divided into three types of models:

i) Characteristics of the perpetrator or perpetrator's family (table 7);

ii) Characteristics of the victim; eg: age - most fatal abuse before two years old (Runyan et al 2002); "special characteristics" like physical disability;

iii) Interaction of the above, and the environment (eg: social isolation, environmental stressors like poverty, cultural norms on gender roles).

BIOLOGICAL FACTORS	COGNITIVE/ AFFECTIVE FACTORS	BEHAVIOURAL FACTORS
- neurological problems	- low self-esteem	- alcohol and drug use
- physical health problems	- depression	- inadequate coping skills
	- inappropriate expectations of child	- frequent use of harsh discipline
FAMILY CHARACTERISTICS		
- marital discord		
- poor communication skills		
- lack of cohesion		

(After Milner and Crouch 1999)

Table 7 - Examples of perpetrator and family characteristics in child physical abuse.

Emery and Laumann-Billings (2002) preferred to integrate the research on causes of CPA and neglect using four levels of analysis:

i) Individual characteristics of the perpetrator including low self-esteem, poor impulse control, and external locus of control. While individual characteristics of the victim may include behavioural problems and poor health;

ii) Immediate context; eg: family stressors. Though there are many families that experience stressful life events and do not abuse their children, so it is more

appropriate to talk of coping style as well as the actual stressor;

iii) Broader ecological context is the community in which the family lives, and includes poverty. But again there are many poor families who do not abuse, so there must be other factors also involved, like "social disorganisation" or lack of community identity;

iv) Societal or cultural context, which is the broad cultural beliefs and values about the socialisation of children, punishment, and the family.

Goodman and Scott (1997) included four groups of factors that predispose to abuse:

i) Child characteristics - eg: difficult temperament, special needs;

ii) Parenting skills - eg: insensitive care of child, psychiatric problems, low intelligence, and past experiences of abuse;

iii) Weak attachment - eg: unwanted pregnancy, step-parent;

iv) Circumstances - eg: lack of social support, poor material situation, and immediate precipitants, like alcohol or drug use.

CHILD PHYSICAL ABUSE AND SPOUSE ABUSE

It has been argued that what happens between the parents (ie: spousal abuse) is important in understanding child abuse (Schaffer 1998).

Rumm et al (2000) made use of a cohort of families in the US army. Between 1989-95 there were 14 270 incidences of child abuse. The cases of child physical abuse were 2.4 times more likely where there was spouse abuse than not. Spouse abuse, however, was not associated with child neglect.

But Tajima's (2000) study of 2733 families, in the 1985 US National Family Violence Study, found that wife abuse was a less important predictor than other characteristics (eg: respondents hit as adolescent) in child physical abuse (table 8). Yet wife abuse was still important in many ways.

	MOST IMPORTANT RISK FACTOR	SECOND MOST IMPORTANT FACTOR	WIFE ABUSE
Child physical abuse	Respondent hit as adolescent (2.27)*	Marital discord (2.23)	5th (1.69)
Use of physical punishment	Wife abuse (2.60)	Childhood problems (2.21)	1st
Both above	Wife abuse (2.56)	Childhood problems (2.18)	1st
Verbal abuse	Marital discord (3.26)	Wife abuse (1.42)	2nd
Any of above	Marital discord (2.94)	Wife abuse (2.32)	2nd

* = ratio of likelihood of abuse with or without this behaviour.

(After Tajima 2000)

Table 8 - Risk factors associated with types of abuse.

Holtzworth-Munroe and Stuart (1994) distinguished, from the literature, three types of spouse abuser:

Type 1 - generally violent at home and outside the home. Their family violence is part of a consistent trait of aggression in all areas of their lives. They are more likely to have anti-social personality traits.

Type 2 - Abuse only in the family, and make up the majority of cases of spouse abuse. Outside the family there may be no evidence of aggression in their lives. Less severe aggression than type 1, and more likely to suppress angry emotions.

Type 3 - Abuse only in the family, but the individuals here are more likely to have mental health problems (eg: schizoid personality traits) than type 2.

MUNCHAUSEN BY PROXY SYNDROME (MBPS)

Munchausen Syndrome is classed as a "factitious disorder" in DSM-IV-TR (APA 2000) ⁽⁵⁾, and involves the individual claiming illness that they do not have or making themselves ill (Feldman and Ford 1994). More disturbing is Munchausen By Proxy Syndrome (MBPS), which involves making another person ill (or pet; Porter 1997).

In a rare number of cases, the CPA will be caused by MBPS (of which 98% of sufferers are female; Emery and Laumann-Billings 2002). In mild cases, the parent

fabricates the illness, but in more serious cases, the child is injured to make the illness real. Feldman and Ford (1994) quoted the case of a mother who trained her four-year old to mimic epileptic seizures.

Some parents with this disorder may ultimately kill their children. Samuels and Southall (1992) felt the risk of mortality was high.

The focus for the MBPS sufferer seems to be gaining attention (Prins 1990):

..a character-disordered parent who finds the support of the hospital staff and/or the drama of the child's purported illness so personally gratifying that the morbidity associated with unnecessary tests and even death of her child becomes secondary to her need to keep the child in the sick role (Rauch and Jellinek 2002 p 1061).

Research on the profile of a MBPS sufferer is limited, but there are common characteristics (listed in table 9).

Parent does not disclose own psychiatric history, which will exist, including deliberate self-harm or suicide attempts (Souid et al 1998)

Mother constantly attentive to child, and appears very caring*

When hospital discovers nature of illness, sufferer responds with anger, and threatens to or actually takes the child away; thus no long-term relationship with medical staff (Schreier and Libow 1993)

Medical condition takes an unexpected course and/or symptoms are inconsistent (parent may appear to have good medical knowledge)

Parent does not seem distressed by persistence of illness (Mrazek 2002)

* Care has to be taken that this characteristic is seen in the context of the others as attentive parents are generally a good thing for a child. Ruach and Jellinek (2003) urged caution:

Just as it is a form of abuse that should not be regarded as trivial, it is also important not to ascribe uncertainty of diagnosis and parental anxiety to this serious form of abuse. Once suspicion of this diagnosis is written in the permanent hospital record, the parent will be viewed with suspicion by every provider to follow (p1061).

Table 9 - Common characteristics of Munchausen By Proxy Syndrome.

MBPS is a difficult disorder to accurately study

because of the secretive nature, but Southall et al (1997) used covert video surveillance in an English hospital.

The study selected 39 children where there was suspicion of the mother inducing the illness. The video surveillance captured thirty of the parents harming their child in the hospital. A further study of the siblings of the 39 target children found that twelve of 41 had died suddenly and unexpectedly.

There are a number of high profile cases of MBPS, for example;

a) Terri Milbrandt in Urbana, Ohio, in 2002, who, over a nine-month period made everybody (including the child's often- away father) believe that her seven-year-old daughter was dying of cancer. Even the daughter herself believed the story.

Milbrandt used the illness as a means to get money from others to pay for medical treatment. When found out, she pleaded "not guilty by reason of insanity", and it came out that she had a history of credit card fraud ("Cutting Edge: A Mother's Love" 2003).

b) Beverly Allit in 1991-2 at a hospital in Lincolnshire. She was convicted of killing four babies and attempting to kill nine more while working as a nurse ("Infamous Murders: Angels of Death" 2001). She injected the babies with insulin. During the police interviews and in court, she showed no emotional response to the events. She is in a secure psychiatric hospital ("Scenes of Crime" 2001).

PREDICTION OF RISK OF ABUSE

The ideal aim of researchers would be the accurate prediction of child abuse from risk factors. The prediction of risk is a holy grail for psychologists and psychiatrists, and is far from a perfect science. One attempt at prediction is through the use of checklists of risk factors, and from these calculating scores of, for example, "conditional probability" ("percentage of families with a particular characteristic that go on to abuse" Browne 2002).

Browne (1995) reported a study to test the accuracy of a twelve-item checklist. The items were common risk factors for child abuse, like "history of family violence" and "parent indifferent, intolerant or overanxious towards child" ⁽⁶⁾.

This study was based on all the births (14 252) in Surrey in 1985 and 1986, and the follow-up at five years

old. By 1991, 106 child were recorded as maltreated.

Table 10 shows that certain of the twelve risk factors were clearly present among abusing than non-abusing families.

CHECKLIST ITEM	ABUSING FAMILIES(%)	NON-ABUSING FAMILIES(%)
Most important risk factors:		
Socioeconomic problems such as unemployment	70.8	12.9
Single or separated parent	48.1	6.9
History of mental illness, drug or alcohol addiction	34.9	4.8
Least important risk factor:		
Infant mentally or physically handicapped	2.8	1.1

(After Browne 2002)

Table 10 - The three most important and one least important risk factors between abusing and non-abusing families.

In terms of predicting at birth the risk of child abuse in the following five years, the checklist was correct for 86% of cases. However, it was also inaccurate in the other 14% of families (table 11).

	ACTUAL ABUSE	ACTUAL NON-ABUSE
PREDICTED ABUSE	68% of abused families correctly predicted as high risk of child abuse	6% of non-abusing families predicted as high risk of child abuse, but did not abuse
PREDICTED NON-ABUSE	32% of abusing families predicted as low risk, but did abuse child	94% of non-abusing families correctly predicted as low risk of child abuse

Table 11 - Accuracy of predicting abuse with checklist used by Browne (1995).

Effects of Child Physical Abuse

The effects of CPA will be varied depending on the nature of the abuse. The extent of the effects will be influenced by a number of factors (Emery and Laumann-Billings 2002):

- i) Nature of the abuse including the frequency, intensity, and duration;
- ii) Individual characteristics of the victim;
- iii) The relationship between the victim and the abuser;
- iv) Response of others to the abuse;
- v) Factors that exacerbate or reduce the effects; eg: age of child (peaks of risk are 3 months to three years old, and adolescence; Azar and Wolfe 1998); how the child makes sense of events (including guilt and self-blame; Wolfe et al 1994).

PHYSICAL CONSEQUENCES OF ABUSE

Baladerian (1991 quoted in Emery and Laumann-Billings 2002) estimated that 18 000 children per year become severely disabled from severe CPA.

Leaving aside the injuries, the effects of physical abuse and maltreatment at an early age were assumed to lead to later problems through psychological means. But research using the latest technology has suggested that such abuse has physical consequences (ie: in brain development) (Teicher 2002).

One possibility is that the early maltreatment leads to the excessive presence of stress hormone during brain development during infancy, and this leaves the limbic system damaged (particularly the amygdala and the hippocampus).

Ito, Glod and Teicher (Teicher 2002) felt that this damage could produce symptoms similar to temporal lobe epilepsy (TLE); eg: abrupt onset of numbness or vertigo, uncontrollable twitching, nausea, or hallucinations.

In 1993, these researchers tested this idea using a checklist of TLE-related symptoms on 253 adults at an outpatient mental health clinic in the USA. The patients who had experienced child abuse scored higher on the checklist than those not ill-treated (table 12).

The use of a checklist of symptoms is based upon the

patient's own recall, and is far from ideal. So the same researchers, from McLean Hospital in Belmont (Mass), looked at brain-wave abnormalities using EEGs.

In 1994 (Teicher 2002), they reviewed the records of 115 consecutive admissions to a child and adolescent psychiatric hospital.

GROUP	% HIGHER SCORES ON CHECKLIST THAN NON-ABUSED PATIENTS
Physical, but not sexual abuse	38
Sexual, but not physical abuse	49
Physical and sexual abuse	113

Table 12 - Child abuse and higher scores on TLE-symptoms checklist.

Brain-wave abnormalities were observed in 54% of the sample who experienced early trauma compared to 27% who had not had early trauma. The abnormalities were in the frontal and temporal brain regions of the left hemisphere mainly.

Subsequent work has used magnetic resonance imaging (MRI) to show a smaller hippocampus and amygdala in adults who experienced early mistreatment (Teicher 2002). The hippocampus is particularly vulnerable to early stress because it develops after birth with the growth of new neurons, and it has a high density of receptors for cortisol (stress-related hormone).

Research in recent years has also found physical differences in other parts of the brain in those children who experienced early abuse - for example, smaller parts of the middle of the corpus callosum (De Bellis et al 1999), and abnormalities in the cerebellar vermis (area close to the brain stem, which controls production of neurotransmitters like dopamine) (Teicher 2000).

This research fits with findings that adults with Post-Traumatic Stress Disorder show changes in brain structure (eg: hippocampus volume) and function (eg: increased regional cerebral blood flow in frontal cortex) (Hull 2002).

Generally research has also focused on the hypothalamic-pituitary-adrenal axis response to early trauma (Glaser 2000).

FATAL ABUSE

The most damaging physical effect of CPA is death. For example, "shaken baby syndrome" which produces craniocerebral injury (ie: brain moves inside skull) can be fatal in one-third of cases, and, when not fatal, leaves the child with brain damage (MacMillan and Munn 2001).

The rates of fatal abuse vary around the world, according to World Health Organisation figures (table 13).

Rate per 100 000 population	0-4 years		5-14 years	
	Male	Female	Male	Female
All countries	13.0	7.7	8.8	6.4
Africa	31.2	21.9	25.9	14.6
Americas	3.8	2.7	3.4	1.8
South East Asia	6.0	4.3	8.9	8.3
Europe	6.5	3.3	7.9	2.1

(After Runyan et al 2002)

Table 13 - Estimated mortality by intentional injury in year 2000.

EMOTIONAL AND BEHAVIOURAL CONSEQUENCES OF ABUSE

There are general concerns about the psychological adjustment of abused children (Wolfe 1999), both in childhood and adulthood.

CPA has been found to be associated with emotional problems (eg: depression, anxiety) in adult women (Malinosky-Rummell and Hansen 1993), increased rates of anti-social behaviour, and substance abuse in adulthood (Kaplan et al 1999), and increased rates of conduct disorder in adolescence (Pelcovitz et al 2000).

Vostanis (2004) reviewed the psychological effects upon children of various trauma: acute trauma, like earthquakes; chronic physical illness; exposure to community and war conflicts.

SOCIAL CONSEQUENCES OF ABUSE

Practically, many children are placed in foster care

as a result of the abuse and neglect (eg: many of the 254 000 children removed from their parents in the US in 1994; Tataara 1996). Placement in foster care has its own consequences for the child (Schaffer 1998).

One big concern relates to whether victims of CPA will abuse their children. Ertem et al (2000) attempted a systematic review of studies published between 1965 and 2000 (over 200) into this issue, but only ten of the studies were accepted as rigorous enough on eight criteria (7).

The best study (Egeland et al 1988) showed that females of low socio-economic status who had experience CPA were 12.6 times more likely to abuse their children than mothers with parents who were emotionally supportive. But another good quality study (Widom 1989) did not find any such risk.

CHILD NEGLECT

Child neglect tends to be less researched than CPA. Neglect is the passive version, if the active side is abuse.

For example, in a good quality longitudinal study in New York state, Johnson et al (2000) found that emotional, physical and supervision neglect were associated with the development of a personality disorder in adulthood.

CHILDREN WHO WITNESS VIOLENCE AND CONFLICT

Research has shown that children who witness family violence, rather than being the victims, display greater psychological disturbance than control children (Schaffer 1998). Even at a young age, children are distressed (eg: crying) by inter-parent fights, and repeated conflict sensitises the child (Cummings et al 1981).

Jaffe et al (1986) found similarities in problem behaviour between children physically abused themselves, and those who had witnessed family violence.

REFUGEE AND ASYLUM-SEEKING CHILDREN

There is a growing body of research into this group of children, but there are ethical constraints on working with unaccompanied minors, for example (Thomas and Byford 2003), of which there were 4400 in 1999 in the UK (Nikapota 2002).

Generally refugee and asylum-seeking children in the UK showed higher levels of behavioural and emotional problems compared to the indigenous population including ethnic minority children living in stable environments (Fazel and Stein 2003).

Studies in other countries have found similar results: eg: Albanian refugee children in Turkey showed higher levels of anxiety and depression than local children (Yurtbay et al 2003).

The causes of the children's problems can be divided into two:

- i) Exposure to trauma before arriving;
- ii) The experience of change including displacement, adapting to a new country, and loss of family and community (Vostanis 2004). Children displaced in their own country can also be affected, particularly if living in a refugee camp.

However, many children who experience refugee status do not show any type of mental disorder (Nikapota 2002). There are many risk and protective factors involved, and a considerable heterogeneity of population and experience (Hodes 2000).

CHILDREN IN ARMED CONFLICT SITUATIONS

Many children around the world are living in situations of armed conflict and war. This situation clearly has consequences for the children.

For example, 88% of Iraqi children had Post-Traumatic Stress Disorder one year after experiencing bombing while in a shelter during the Gulf War, and 79% two years after the event (Karam and Bou Ghosa 2003).

Somasundaram (2002) has studied children in the civil war in North East Sri Lanka, both those who become child soldiers and schoolchildren generally. Of a group of over 600 adolescents in Vaddukoddai (North Sri Lanka), each child had experienced an average of four war-related stressors, like detention, displacement, or witnessed violence. Thirty-one per cent of the adolescents were diagnosed as having Post-Traumatic Stress Disorder and 21% depression.

Among 305 younger schoolchildren in the same area of Sri Lanka, the biggest problems were sleep disturbances (88%), separation anxiety (40%), and hyperalertness (50%).

Thabet et al (2002) assessed 91 Palestinian children exposed to home bombardment and demolition during the Al Aqsa Intifada, and 89 controls exposed to other political

violence in Gaza. The data were collected in January and February 2001. The exposed group had greater levels of "severe" and "very severe" Post-Traumatic Stress Disorder compared to the controls (59% vs 25%). But the control group had more anticipatory anxiety, and cognitive expressions of distress.

Children and Disadvantage

A key impact on children is made by poverty. Poverty is associated with poor parental mental health, greater family conflict, and negative parent-child interactions (Marks et al 2002). All of these factors affect the child in different ways.

For example, poor children are more likely to suffer from psychiatric disorders among other disadvantages compared to richer children, as shown in a study in Ontario, Canada of over 3000 children (Offord 1991) (table 14).

The effects of poverty are greater in the preschool years than middle childhood, and the longer the child living in poverty, the greater the negative outcomes (Brooks-Gunn et al 1999).

Research has attempted to explain the mechanisms by which poverty leads to childhood problems. It is difficult to isolate poverty from other negative variables like family conflict, but one possibility is that low income creates economic pressures leading to parental conflict. This conflict affects the child itself, or leads to inattention from parents, or produces harsh parenting, and these create the negative outcomes for the child (Conger et al 1997).

	POOR CHILDREN*	MIDDLE CLASS CHILDREN
Diagnosed psychiatric disorder	31.6	13.8
Poor school performance	29.7	13.3
Social impairment	11.9	11.6
Chronic health problems	30.1	17.6
Teacher-identified conduct disorders	15.6	2.6

(* Annual family income less 10 000 Canadian dollars)

Table 14 - Percentage incidence of problems between children from poor and middle class families.

Another explanation comes from Mayer (1997), who argued that the genetic factors that caused the parents to be in poverty (eg: low intelligence) are also present in the offspring.

Furthermore, the limiting factors in the parents reduces their ability to care for their offspring. Though there are risk factors for CPA, like low intelligence,

there are also many cases where abuse does not take place. So care should be taken when suggesting that those in poverty are there because of genetic factors. Otherwise we can end up blaming the victim (Walker 1990), and ignoring the role of the capitalist system in creating poverty (Gans 1973).

Poverty is part of a risk environment, and:

The common theme across all of these chronic risk environments is that children are immersed in a context that can be threatening, disorganised, unpredictable, harsh and conflictual (Friedman and Chase-Lansdale 2002 p267).

A variation of living in poverty is the case of children working or living on the street. Studies in a number of countries (eg: Ethiopia: Lalov 1999; Brazil: Campos et al 1994) showed that streetchildren are highly vulnerable to abuse and victimization.

Offord (2001) proposed four guiding principles for intervention programmes to reduce the effect of poverty generally on children's mental health:

i) Gradient - the relationship between family income and childhood problems is a negative correlation, and there is no income threshold. Thus any programme focused only on poor children will ignore the problems of children in higher income families.

ii) Universality - this principle including equal access, equal participation, and "equitable outcomes" (ie: same range of outcomes for all children, not necessarily equal outcomes).

iii) First five years - importance of early years for healthy brain development.

iv) Strategies for delivering the programme - eg: "civic community" where all children have the right to full participation in community life.

Another aspect of disadvantage is malnutrition. A standard definition of malnutrition often used is height or length for age more than two standard deviations below median of National Centre for Health Statistics/World Health Organisation reference population (WHO 1983).

Malnutrition is not only associated with poor growth and subsequent mortality, but also enduring effects on cognitive development (Drewett 1996). For example, in an inner city study in Britain, children classed as below

the 10th centile for both weight and height (ie: lowest 10% of the population) had an average IQ of 20 points lower than the control group at 4 years old (Skuse et al 1994).

MULTIPLE FORMS OF ABUSE AND DISADVANTAGE

Recent research has moved away from the focus upon the effect of a single type of abuse to look at the combination of abuse(s), neglect, disadvantage, and family dysfunction. Together called "adverse childhood experiences" (ACEs). These include parental substance abuse, family violence, criminal activity in the household, and parental marital discord, which can co-occur with childhood abuse.

Dong et al (2004) studied the amount of multiple ACEs among over 8600 adults in San Diego, California. The study concentrated on ten ACEs (listed in table 15).

- Emotional abuse: including insults or threat of harm
- Physical abuse: push, grab, slap, or throw something at, and hit to leave mark or injury
- Sexual abuse
- Emotional neglect: eg: not feeling loved by any family member
- Physical neglect: eg: "I didn't have enough to eat"
- Domestic violence
- Household substance abuse
- Mental illness in household
- Parental separation or divorce
- Criminal household member

Table 15 - Ten ACEs in Dong et al (2004) study.

The results showed the existence of multiple ACEs in individuals who experienced child abuse (table 16). Those individuals who experienced CPA were seventeen more likely to have experienced emotional abuse, and four times more likely to have witnessed domestic violence than individuals not physically abused. Those individuals who had been physically neglected were much more likely to also be emotionally neglected (twelve times), and to have experienced emotional abuse (six times) than non-neglected individuals.

	PREVALENCE (%)	ADDITIONAL ACES (%)		
		0	1	6+
Emotional abuse	10.2	2	98	25
Physical abuse	26.4	17	83	12
Emotional neglect	14.8	7	93	19
Physical neglect	9.9	11	89	24

(After Dong et al 2004)

Table 16 - Number of individuals experiencing abuse or neglect, and additional ACEs.

Prevention and Response to Child Abuse and Neglect

The financial cost to society of child abuse and neglect are very large, let alone the non-financial cost to the victim. It is estimated that, in the US, two million child abuse and neglect cases cost 12 410m dollars (including 570m for medical care, and 5 110m mental health care) (quoted in WHO 1999).

While in England and Wales, the figure of £735m per year for child protection was quoted (National Commission of Enquiry into the Prevalence of Child Abuse 1996).

Browne (2002) listed the three levels of prevention of child maltreatment:

- i) Primary prevention - universal services for the whole population;
- ii) Secondary prevention - targeted services at high-risk groups;
- iii) Tertiary prevention - specialist services where maltreatment has already occurred.

Runyan et al (2002) summarised the most common responses to child abuse from around the world (table 17).

CPA and neglect can be reduced by universal programmes that improve the life conditions of all children (eg: housing, financial support). While target programmes focus on vulnerable groups, like disadvantaged families, with home visits.

The Prenatal and Early Childhood Nurse Home Visitation Program has been used, and studied, in Elmira, New York, and Memphis, Tennessee. Nurse home visitors work closely with families through pregnancy and into early childhood.

Olds et al (1997), in a fifteen-year follow-up, found 79% less child maltreatment compared to the control group. There were other benefits to the programmes, like less maternal alcohol and drug abuse.

For home visiting programmes to be successful, they should begin during pregnancy, and be regular enough to build trust. There should also be strategies to deal with reservations from other family members (eg: fathers), and substance abuse problems (Offord and Bennett 2002).

APPROACH**EVALUATION STUDY**

<u>1. Family Support</u>	
a. Training in parenting eg: Triple P- Positive Parenting Programme in Queensland, Australia	Wolfe et al (1988)
b. Home visit and other family support programmes eg: Parent Centre, Cape Town, South Africa	Olds et al (1997) - 15 year follow-up of Prenatal and Infancy Home Visitors' Program in USA
c. Intensive family prevention services; eg: Homebuilders in USA giving 24 hour on-call services to "at risk" families	MacLeod and Nelson (2000) meta-analysis
<u>2. Health service</u>	
a. Screening by health care professionals; ie: identifying maltreatment	No evaluation known on improved referral of children (Runyan et al 2002)
b. Training for professionals	
<u>3. Therapeutic</u>	
a. Services for victims eg: playgroups for socially withdrawn, abused children	Fantuzzo et al (1988)
b. Services for children who witness violence	Wagar and Rodway (1995)
c. Services for adults abused as children	Few published evaluations
<u>4. Legal and related remedies</u>	
a. Mandatory or voluntary reporting by health care professionals	
b. Child protection services	
c. Child fatality review teams in US to improve accuracy of classification of children's deaths	
d. Arrest and prosecution policies	
e. Mandatory treatment of offenders	
<u>5. Community-based efforts</u>	
a. School programmes eg: "Stay Safe" in Republic of Ireland for child sexual abuse	Rispens et al (1997) meta-analysis
b. Prevention and educational programmes; eg: 1991-2 multi-media campaign in Holland increased rates of disclosure	Hoefnagels and Baartman (1997)
c. Interventions to change community attitudes and behaviour; eg: Kenya in 1996 coalition formed to increase awareness and provide services, and led to "Children Legal Action Network"	
<u>6. Societal approaches</u>	
a. National policies and programmes	
b. International treaties; eg: Convention on the Right of the Child produced by United Nations in 1989	

Table 17 - Different types of approaches to dealing with child abuse.

SUPPORTIVE INTERVENTIONS

For mild levels of abuse, programmes based upon teaching parents new skills using behavioural approaches can be useful (eg: Project 12-Ways in rural Illinois; Lutzker et al 1998). These behavioural approaches include (Emery and Laumann-Billings 2002):

i) Teaching and modelling appropriate responses to children's difficult behaviour.

ii) Cognitive restructuring of inappropriate interpretations of children's behaviour. Often the parent in child abuse situations is making inappropriate attributions of the child's behaviour: for example, a young baby crying a lot is seen as doing it on purpose to annoy the adult.

Similarly, Dodge (1986) has noted a "hostile attribution bias" among violent offenders. This is the tendency to perceive ambiguous events as a direct attack upon themselves, and this prompts their violent response. Cognitive restructuring involves changes these and other such attributions.

iii) Anger control techniques (ACT). Anger control programmes were developed by Raymond Novaco (1975), and emphasise the role of the thoughts that precede an angry reaction. ACT help individuals to be aware of the whole process of how they become angry, and, in the case, of CPA, how this leads to physical aggression towards the child.

iv) Skills training for managing the child without the use of physical punishment.

The likelihood of the success of such programmes will be reduced by such factors as substance abuse, lack of empathy for the child, and disordered attachment, among others (Emery and Laumann-Billings 2002).

Scott (2002) outlined the five stages of a typical parent training programme set up over 8-12 one-two hour sessions at the Maudsley Hospital in London:

Part 1: Techniques for promoting the child-centred approach; eg: parent playing with the child, but the parent follows the child's behaviour.

Part 2: Increase acceptable child behaviour; eg: use of reward charts.

Part 3 - Setting clear expectations; eg: "when-then" commands ("when you've done your homework, then you can

play outside").

Part 4 - Reducing unacceptable child behaviour; eg: ignoring child as lack of reinforcement.

Part 5 - Strategies for avoiding trouble; eg: negotiating and planning skills.

COERCIVE INTERVENTIONS

This involves legal interventions including the termination of parental rights. The question is when such interventions should or should not be used, and whether there should be early intervention (Azar et al 1995).

Footnotes

1. Traditionally, this is divided into "failure to thrive" (FTT) caused by biological factors, and "non-organic failure to thrive" (NOFT) due to inadequate food intake. Usually it is seen as weight below the third percentile (ie: lowest 30% of weight for age norms).

With NOFT, a number of reasons have been suggested for inadequate food intake - child abuse, caregiver-child relationship problems, financial problems, maternal mental health problems, and disorganised feeding (Stein and Barnes 2002).

2. Schaffer (1998) felt that slapping children occasionally is not psychologically harmful, nor that such behaviour automatically escalates to worse physical punishment or violence. Neither has physical abuse been eradicated in European countries where physical punishment is illegal.

Larzelere (1996) reviewed 35 studies of parents' use of non-abusive physical punishment. Only 12 of the studies reported negative effects, 14 studies were neutral, and the remainder found beneficial outcomes for the child.

3. Brewer (2004) explored the different methodologies and problems in measuring child sexual abuse.

4. The figures show increases in the rate of abuse between 1980 and 1993, is this a real increase? Some of the increase will be due to greater public awareness, but the number of serious cases has increased drastically compared to less severe cases. NIS-2 included 142 000 serious cases of CPA in 1986, and NIS-3 565 000 cases (Sedlak and Broadhurst 1996). Because there has been no equivalent increase in other types of cases, which would be expected if the increase was due to greater recognition or "definitional creep" (Besharov 1996), then the figures can be seen as evidence of a real increase in CPA.

5. DSM-IV-TR is the classification system for mental disorders produced by the American Psychiatric Association.

6. Table 18 gives the complete list of 12 risk factors used in Browne (1995) study.

1. History of family violence
2. Parent indifferent, intolerant or overanxious towards child
3. Single or separated parent
4. Socioeconomic problems, such as unemployment

5. History of mental illness, drug or alcohol addiction
6. Parent abused or neglected as child
7. Infant premature, low birth weight
8. Infant separated from mother for more than 24 hours post-delivery
9. Mother younger than 21 years old at time of birth
10. Step-parent or co-habitee parent
11. Less than 18 months between birth of children
12. Infant mentally or physically handicapped

(After Browne 2002)

Table 18 - Twelve risk factors for child abuse and neglect used by Browne (1995).

7. The aim of this review was to include good quality studies only. Ertem et al (2000) devised eight criteria by which to measure this:

i) Equal demographic and clinical susceptibility - whether the studies controlled for socio-economic status and family characteristics, for example, between the abused and non-abused groups;

ii) Clear description of the abuse experienced as a child;

iii) Avoided recall and detection bias - the researchers tried to avoid studies which only measured child abuse by asking parents accused of abusing their children whether they had experienced abuse themselves;

iv) Ensuring non-abuse of controls - it was important that the control group had not experienced abuse, and a good quality study needed to check this first;

v) Clear definition of outcome - clear definition of the abuse committed (ie: outcome event);

vi) Equal surveillance of both groups for the outcome event - equal follow-up of both abused and non-abused groups to see who was committing child abuse themselves;

vii) Adequate control for intervening variables - whether the studies attempted to control for other variables, like birth order or period in foster care after abuse discovered.

viii) Clear description of person who abused - ie: establish that parent who was abused does commit abuse.

Figure 1 shows the design for the ideal study.

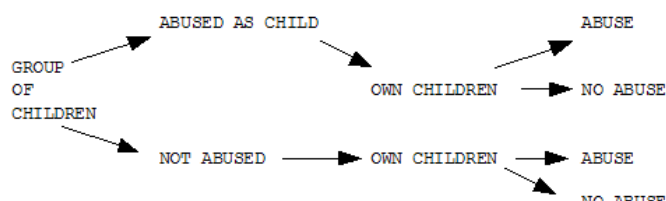


Figure 1 - Ideal design for study into generational continuity of child abuse.

Not all of the ten studies used by Ertem et al in their review met all eight methodological criteria. Table 19 shows the number of criteria met, and the relative risk of abused children becoming abusers themselves compared to non-abused children.

NUMBER OF STUDIES	NUMBER OF METHODOLOGICAL CRITERIA MET	RELATIVE RISK OF BECOMING ABUSER
2	1	4.44 - 4.75
3	3	2.75 - 37.8
1	4	not calculated
2	5	1.16 - 1.57
1	6	1.05
1	8	12.6

Table 19 - Number of methodological criteria met by studies reviewed and relative risk of becoming an abuser found.

References

APA (2000) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (4th ed - text revision), Washington DC: American Psychiatric Association

Azar, S.T & Wolfe, D (1998) Child physical abuse and neglect. In Mash, E.J & Barkley, R.J (eds) Treatment of Childhood Disorders (2nd ed), Washington DC: American Psychological Association

Azar, S.T; Benjet, C.L; Fuhrmann, G.S & Cavallero, L (1995) Child maltreatment and the termination of parental rights: can behaviour research help Solomon? Behavioural Therapy, 126, 599-623

Benedict, M.I et al (1994) Types and frequency of child maltreatment by family foster care providers in an urban population, Child Abuse and Neglect, 18, 577-585

Besharov, D.J (1996) Child abuse: threat or menace? How common is it really? Slate, 9, 1-5

Brewer, K (2004) Measuring the amount of child sexual abuse: the problems, Orsett Psychological Review, June, 13, 23-32

- Brooks-Gunn, J; Duncan, G.J & Maritato, N (1997) Poor families, poor outcomes: the well-being of children and youth. In Duncan, G.J & Brooks-Gunn, J (eds) Consequences of Growing Up Poor, New York: Russell Sage Foundation
- Browne, K (1995) Predicting maltreatment. In Reder, P (ed) Assessment of Parenting, Chichester: Wiley
- Browne, K (2002) Child protection. In Rutter & Taylor op cit
- Browne, K & Herbert, M (1997) Preventing Family Violence, Chichester: Wiley
- Campos, R et al (1994) Social networks and daily activities of street youth in Belo Horizonte, Brazil, Child Development, 65, 319-330
- Conger, R.D; Conger, K.J & Elder, G.H (1997) Family economic hardship, and adolescent adjustment: mediating and moderating processes. In Duncan, G.J & Brooks-Gunn, J (eds) Consequences of Growing Up Poor, New York: Russell Sage Foundation
- Cummings, E.M; Zahn-Wexler, C & Radke-Yarrow, M (1981) Young children's responses to expressions of anger and affection by others in the family, Child Development, 52, 1274-1282
- Cutting Edge: A Mother's Love (2003), Channel 4 Television
- De Bellis, M.D et al (1999) Developmental traumatology Part 2: brain development, Biological Psychiatry, 45, 10, 1271-1284
- Dodge, K (1986) A social information processing model of social competence in children. In Perlmutter, M (ed) The Minnesota Symposium of Child Psychology, Hillsdale, NJ: Erlbaum
- Dong, M et al (2004) The interrelatedness of multiple forms of child abuse, neglect, and household dysfunction, Child Abuse and Neglect, 28, 771-784
- Drewett, R (1996) Malnutrition and the world's children. In Hatcher, D (ed) 1996 ATP Conference, Leicester: Association for the Teaching of Psychology
- Egeland, B; Jacobvitz, D & Sroufe, A (1988) Breaking the cycle of abuse, Child Development, 59, 1080-1088
- Emery, R & Laumann-Billings, L (1998) An overview of the nature, causes and consequences of abusive family relationships: towards differentiating maltreatment and violence, American Psychologist, 53, 121-135
- Emery, R & Laumann-Billings, L (2002) Child abuse. In Rutter & Taylor op cit
- Ertem, I.O; Leventhal, J.M & Dobbs, S (2000) Intergenerational continuity of child physical abuse: how good is the evidence? Lancet, 356, 814-819
- Fantuzzo, J.W et al (1988) Effects of adult and peer social initiations on the social behaviour of withdrawn, maltreated preschool children, Journal of Consulting and Clinical Psychology, 56, 34-39
- Fazel, M & Stein, A (2003) Mental health of refugee children: a comparative study, British Medical Journal, 327, 133-134
- Feldman, M.D & Ford, C.V (1994) Patient or pretender, New York: Wiley
- Friedman, R.J & Chase-Lansdale, P.L (2002) Chronic adversities. In Rutter & Taylor op cit
- Gallup, G.H; Moore, D.W & Schussel, R (1995) Disciplining Children in America: A Gallup Poll Report, Princeton, NJ: Gallup Organisation

- Gans, H.J (1973) *More Equality*, New York: Pantheon
- Glaser, D (2000) Child abuse and neglect and the brain - a review, *Journal of Child Psychology and Psychiatry*, 41, 97-116
- Goodman, R & Scott, S (1997) *Child Psychiatry*, Oxford: Blackwell Science
- Hamarman, S & Bernet, W (2000) Evaluating and reporting emotional abuse in children: parent-based, action-based focus aids in clinical decision-making, *Journal of the American Academy of Child and Adolescent Psychiatry*, 39, 928-930
- Haugaard, J.J (1999) Epidemiology of family violence involving children. In Ammerman, R.T & Hersen, M (eds) *Assessment of Family Violence* (2nd ed), New York: John Wiley
- Hoafnagels, C & Baartman, H (1997) On the threshold of disclosure: the effects of a mass media field experiment, *Child Abuse and Neglect*, 21, 557-573
- Hobbs, G; Hobbs, C & Wynne, J (1999) Abuse of children in foster and residential care, *Child Abuse and Neglect*, 23, 1239-1252
- Hodes, M (2000) Psychologically distressed refugee children in the UK, *Child Psychology and Psychiatry Review*, 5, 57-68
- Holtzworth-Munroe, A & Stuart, G.L (1994) Typologies of male batterers: three subtypes and the differences among them, *Psychological Bulletin*, 116, 476-497
- Hull, A (2002) Neuroimaging findings in Post-Traumatic Stress Disorder, *British Journal of Psychiatry*, 181, 102-110
- Infamous Murders: Angels of Death* (2001), The History Channel
- Jaffe, P et al (1986) Similarities in behaviour and social maladjustment among child victims and witnesses to family violence, *American Journal of Orthopsychiatry*, 56, 142-146
- Johnson, J.G et al (2000) Associations between four types of childhood neglect and personality disorder symptoms during adolescence and early adulthood: findings of a community-based longitudinal study, *Journal of Personality Disorder*, 14, 171-187
- Jones, D.N; Pickett, J; Oates, M.R & Barbor, P (1987) *Understanding Child Abuse* (2nd ed), London: Macmillan
- Kaplan, S.J; Pelcovitz, D & Labruna, V (1999) Child and adolescent abuse and neglect research: a review of the past ten years. Part 1: physical and emotional abuse and neglect, *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 1214-1222
- Karam, E & Bou Ghosa, M (2003) Psychosocial consequences of war among civilian populations, *Current Opinion in Psychiatry*, 16, 413-419
- Kempe, C.H et al (1962) The battered child syndrome, *Journal of the American Medical Association*, 181, 17-24
- Korbin, J.E (1997) Culture and child maltreatment. In Helfer, M.E et al (eds) *The Battered Child*, Chicago: University of Chicago
- Lalor, K.J (1999) Streetchildren: a comparative perspective, *Child Abuse and Neglect*, 23, 759-770
- Larzelere, R.E (1996) A review of parental use of non-abusive or customary physical punishment, *Pediatrics*, 98, 824-828
- Lutzker, J.R et al (1998) An ecobehavioural model for prevention and treatment of child abuse and neglect: history and applications. In Lutzker, J.R (ed) *Handbook of Child Abuse Research and Treatment*, New York: Plenum

Press

MacLeod, J & Nelson, G (2000) Programmes for the promotion of family wellness and the prevention of child maltreatment: a meta-analytic review, *Child Abuse and Neglect*, 24, 1127-1149

MacMillan, H.L & Munn, C (2001) The sequelae of child maltreatment, *Current Opinion in Psychiatry*, 14, 325-331

MacMillan, H.L et al (1997) Prevalence of child physical and sexual abuse in the community: results from the Ontario Health Survey, *Journal of the American Medical Association*, 278, sup, 131-135

Malinosky-Rummell, R & Hansen, D.J (1993) Long term consequences of childhood physical abuse, *Psychological Bulletin*, 114, 68-79

Marks, M.N; Hipwell, A.E & Kumar, R.C (2002) Implications for the infant of maternal puerperal psychiatric disorders. In Rutter & Taylor op cit

Mayer, S.E (1997) *What Money Can't Buy: Family Income and Children's Life Chances*, Cambridge, MA: Harvard

McCurdy, K & Daro, D (1993) *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1992 Annual Fifty State Survey*, Chicago: National Centre on Child Abuse Prevention Research

Milner, J.S & Crouch, J.L (1999) Child physical abuse: theory and research. In Hampton, R.L (ed) *Family Violence* (2nd ed), Thousand Oaks, CA: Sage

Mrazek, D.A (2002) Psychiatric aspects of somatic disease and disorders. In Rutter & Taylor op cit

National Commission of Enquiry into Prevention of Child Abuse (1996) *Childhood Matters*, London: National Society for Prevention of Cruelty to Children

Nikapota, A (2002) Cultural and ethnic issues in service provision. In Rutter & Taylor op cit

Novaco, R (1975) *Anger Control: The Development and Evaluation of an Experimental Treatment*, Lexington: DC Heath

Offord, D.R (1991) Growing up poor in Ontario, *Transitions*, June, 10-11

Offord, D.R (2001) Reducing the impact of poverty on children's mental health, *Current Opinion in Psychiatry*, 14, 299-301

Offord, D.R & Bennett, K.J (2002) Prevention. In Rutter & Taylor op cit

Olds, D et al (1997) Long-term effects of home visitation on maternal life course and child abuse and neglect: 15 year follow-up of a randomised trial, *Journal of the American Medical Association*, 278, 637-643

Pelcovitz, D et al (2000) Psychiatric disorders in adolescents exposed to domestic violence and physical abuse, *American Journal of Orthopsychiatry*, 70, 360-369

Porter, M (1997) Why Baz's baby is in danger, *Radio Times*, 25/1, p30

Prins, H (1990) *Bizarre Behaviour*, London: Routledge

Rauch, P.K & Jellinek, M.S (2002) Paediatric consultation. In Rutter & Taylor op cit

Rispens, J; Aleman, A & Goudana, P.P (1997) Prevention of child sexual abuse victimization: a meta-analysis of school programs, *Child Abuse and Neglect*, 21, 975-987

Rumm, P.D et al (2000) Identified spouse abuse as a risk factor for

child abuse, *Child Abuse and Neglect*, 24, 11, 1375-1381

Runyan, D et al (2002) Child abuse and neglect by parents and other caregivers. In Krug, E et al (eds) *World Report on Violence and Health*, Geneva: World Health Organisation

Rushton, A & Minnis, H (2002) Residential and foster family care. In Rutter & Taylor op cit

Rutter, M & Taylor, E (2002) (eds) *Child and Adolescent Psychiatry* (4th ed), Oxford: Blackwell

Samuels, M & Southall, D (1992) Munchausen-Syndrome-By-Proxy, *British Journal of Hospital Medicine*, 47, 759-762

Scenes of Crime (2001), UKTV

Schaffer, H.R (1998) *Making Decisions About Children* (2nd ed), Oxford: Blackwell

Schreier, H & Libow, J (1993) *Hurting for Love: Munchausen's Proxy Syndrome*, New York: Guilford Press

Scott, S (2002) Parent training programmes. In Rutter & Taylor op cit

Sedlak, A.J & Broadhurst, D.D (1996) *Third National Incidence Study for Child Abuse and Neglect*, Washington DC: US Dept of Health and Human Services

Sidebotham, P et al (2000) Patterns of child abuse in early childhood, a cohort study of the "children of the 90s", *Child Abuse Review*, 9, 311-320

Skuse, D; Pickles, A; Wolke, D & Reilly, S (1994) Postnatal growth and mental development: evidence for a sensitive period, *Journal of Child Psychology and Psychiatry*, 35, 521-546

Somasundaram, D (2002) Child soldiers: understanding the context, *British Medical Journal*, 25/5, 1268-1271

Soud, A; Keith, D & Cunningham, D (1998) Munchausen syndrome by proxy, *Clinical Pediatrics*, 37, 497-503

Southall, D.P et al (1997) Covert video recordings of life-threatening child abuse: lessons for child protection, *Pediatrics*, 100, 735-774

Stein, A & Barnes, J (2002) Feeding and sleep disorders. In Rutter & Taylor op cit

Straus, M.A (1995) *Manual for the Conflict Tactics Scales*, Durham, NH: Family Research Lab, University of New Hampshire

Tajima, E.A (2000) Relative importance of wife abuse as a risk factor for violence against children, *Child Abuse and Neglect*, 24, 11, 1383-1398

Tatara, T (1996) *US Child Substitute Care Flow Data for FY 1994 and Trends in the State Child Substitute Care Populations: Technical Report*, Washington DC: American Public Welfare Association

Taylor, S (1992) Measuring child abuse *Sociology Review*, Feb, 23-27

Teicher, M.H (2000) Wounds that time won't heal: the neurobiology of child abuse, *Cerebrum*, 2, 4, 50-67

Teicher, M.H (2002) Scars that won't heal: the neurobiology of child abuse, *Scientific American*, March, 54-61

Thabet, A.A.M; Abel, Y & Vostanis, P (2002) Emotional problems of Palestinian children living in a war zone: a cross-sectional study, *Lancet*, 25/5, 1801-1804

Thomas, S & Byford, S (2003) Research with unaccompanied children seeking asylum, *British Medical Journal*, 327, 1400-1402

Vostanis, P (2004) The impact, psychological sequelae and management of trauma affecting children, *Current Opinion in Psychiatry*, 17, 269-273

Wagar, J.M & Rodway, M.R (1995) An evaluation of a group treatment approach for children who have witnessed wife abuse, *Journal of Family Violence*, 10, 295-306

Walker, A (1990) Blaming the victims. In Murray, C (ed) *The Emerging British Underclass*, London: Institute of Economic Affairs

Wang, C.T & Harding, K (1999) *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1998 Annual Fifty State Survey*, Chicago: National Centre for Child Abuse Prevention Research

WHO (1983) *Measuring Change in Nutritional Status. Guidelines for Assessing the Nutritional Impact of Supplementary Feeding Programmes for Vulnerable Groups*, Geneva: World Health Organisation

WHO (1999) *Report of the Consultation on Child Abuse Prevention*, Geneva: World Health Organisation

Widom, C.S (1989) Child abuse, neglect and adult behaviour: research design and findings on criminality, violence and child abuse, *American Journal of Orthopsychiatry*, 59, 355-367

Wolfe, D.A (1999) *Child Abuse: Implications for Child Development and Psychopathology* (2nd ed), Thousand Oaks, CA: Sage

Wolfe, D.A; Sas, L & Wekerle, C (1994) Factors associated with the development of post-traumatic stress disorder among child victims of sexual abuse, *Child Abuse and Neglect*, 18, 37-50

Wolfe, D.A et al (1988) Early intervention for parents at risk of child abuse and neglect, *Journal of Consulting and Clinical Psychology*, 56, 40-47

Yurtbay, T et al (2003) The psychological effects of forced emigration on Muslim Albanian children and adolescents, *Community Mental Health Journal*, 39, 203-212